STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245635	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns on Fountain Lake	1771 Eagle View Circle Albert Lea, MN 56007

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355 Based on interview and document review the facility failed to safely use a full body mechanical lift per manufacturer's recommendations for 1 of 3 residents (R1) reviewed who used a mechanical lift. This resulted in harm when R1 fell from a full body mechanical lift causing ongoing pain in shoulders and neck region. In addition the facility failed to ensure comprehensive assessments were completed to determine proper sling size for 3 of 3 residents (R1, R2, and R3) who required transfers with a mechanical lift. Findings include: R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was alert and with diagnosis of quadriplegia, bilateral range of motion impairment to both upper and lower extremities. R1 was dependent with all activities of daily living (ADLs) except for eating, which required set up only and used a electric wheelchair independently. R1's Nursing Assessment for Total Mechanical lift dated 4/13/24 indicated R1 was deemed unsafe to use standing lift. The assessment directed staff to use the Hoyer lift (brand of full body mechanical lift) with two staff assist. The assessment did not address sling size and type. R1's care plan dated 7/10/24, directed staff to transfer R1 with a Hoyer lift with two staff, but did not identify size or type of sling to use during transfers. R1's progress notes dated 7/5/24 at 11:45 p.m., indicated at 11:10 p.m. R1 fell from Hoyer sling during transfer. R1 reported he had hit his head and his upper back. R1 rated his pain at 7/10 and was given Tylenol. Nurse discussed with R1 option of going into the emergency room (ER) to be further evaluated for any injuries, R1 declined further ER evaluation multiple times. No visible injuries noted. No swelling, redness or bruising noted anywhere at this time. Director of nursing (DON) notified by phone. Fall protocol worksheet initiated and continue to monitor. R1's Post Fall Evaluation dated 7/6/24 at 7:46 a.m., indicated R1 vocalized a pain rating of 7/10 and was a new issue. No further documentation noted. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's situation background assessment, and recommendation (SBAR) progress note dated 7/9/24 at 10:44 a.m. identified R1 had a fall on 7/5/24, within the last week has had an increase in pain in the back and neck, recommendation to be seen at the clinic and have a CT scan completed to rule out fractures. R1's progress note dated 7/9/24 at 11:47 a.m., indicated R1 left the facility at 11:00 a.m. and returned at 2:45 p.m. R1's hospital After Visit Summary dated 7/9/24 indicated R1 was seen in the emergency room for back pain. R1 was administered an injection of Ketoralac 15 milligrams (mg) (non-steroidal anti-inflammatory medication to relieve pain). Imagining tests were completed with no new findings or fractures. New orders included: Tylenol 1000 milligrams (mg) every 6 hours for pain, could also take 600 mg of ibuprofen every 6 hours, and use topical over the counter patches such as lidocaine or Salonpas and over the counter ointments/creams Voltaren gel or Asper to assist with pain control. Apply ice and/or heat for 20 minutes at a time multiple times per day and can alternate ice and heat. R1's medication administration record (MAR) was reviewed for June and July 2024. The June MAR included a physician order for Acetaminophen (Tylenol) hydrocodone (narcotic pain medication) 325/5 milligrams (mg) three times a day; R1's average pain rating was marked 4 and 5 out of 10 scale (10 being the most severe). June's MAR also identified an order for as needed (PRN) Tylenol 1000 mg every two hours; MAR identified one administration on 6/22/24 for pain level of 8 out of 10. July's MAR identified the aforementioned orders. The pain rating for the scheduled Acetaminophen/hydrocodone identified increased pain ratings between 7/5/24 and 7/11/24 after the fall. R1 reported pain 6/10 on five occasions and 7/10 pain on 4 occasions. July's MAR also identified R1 was administered PRN Tylenol on 10 occasions between 7/5/25 through 7/11/24; R1 reported pain rated 6/10 prior to one administration, pain rated 7/10 prior to eight administrations, and pain rated 8/10 prior to one administration. R1's Nursing Assessment for Total Mechanical lift dated 7/25/24 indicated R1 was deemed unsafe to use standing lift; R1 could follow commands but not always cooperative. The summary included: Hoyer lift was appropriate and effective in transfers using two assist due to medical diagnoses. The assessment did not address the sling size or type. During an interview on 7/25/24 at 11:22, R1 recalled his fall from the lift on 7/5/24. R1 stated nursing assistant (NA)-B and NA-H were transferring him from his wheelchair to his bed with a mechanical lift when the right shoulder sling loop/strap came off the lift causing him to fall to the floor. R1's voice became rigid and abrasive as he explained his frustration that he had to go the hospital several days later on 7/9/24 to make sure nothing was broke even though he continued to have pain currently from this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/25/24 at 4:00 p.m., NA-B indicated on 7/5/24 at approximately 11:00 p.m. NA-H was helping him transfer R1 from his wheelchair to his bed. NA-B explained R1 was raised into the air and while the lift was pushed toward the bed, the right upper lift strap came off the lift hook causing R1 to fall approximately 3 feet to the floor. NA-B indicated they connected the sling to the lift the normal way, NA-B connected his side and NA-H connected her side. NA-B was not able to articulate why the strap came off of the lift and did not identify tension was checked prior to moving the lift away from the wheelchair. The NA's called for the nurse over the radio. RN-H arrived to the room and they used the same lift to get R1 off the floor and into bed after RN-H did an assessment. NA-B stated R1 was complaining of pain in his neck and back. NA-B indicated staff used whatever sling was in the room and was not able to articulate how sling sizes were determined. NA-B indicated the lift was not removed from operation per for a safety inspection immediately following the fall. During an interview on 7/25/24 at 4:07 p.m., NA-H indicated on 7/5/24 she was assisting NA-B with R1's bedtime cares. We (NA-H and NA-B) were transferring R1 from his chair to his bed. They moved the lift away from the chair and that is when the right upper sling strap, which was on NA-B's side of the lift, came off causing R1 to fall backwards to the floor. Initially NA-H thought the sling broke, but everything was fine. NA-H indicated the loop must not have been all the way around the hook and more resting on top of the hook, indicating they had not checked for the tension prior to moving. NA-H stated they called for the nurse immediately. RN-H responded, she checked R1 for injury and checked the lift to make sure it worked. After that was done, a different sling was used to get R1 off the floor into bed. R1 was complaining of pain in his upper back and shoulder area. NA-H indicated staff used whatever sling was in the room and was not able to articulate how sling sizes was determined. NA-H further stated the lift was not removed from the floor for inspection after the incident. The facility's fall investigation was reviewed; the investigation did not address and/or identify if the appropriate sling size and type that was used at the time of R1's transfer. The facility's Vulnerable Adult Investigation Form for NA-H dated 7/6/24 at 10:30 a.m. signed by DON indicated NA-H, reported We were putting resident to bed and hook up sling to the hoyer, we made sure the sling was attached. We lifted resident up and one of the straps snapped off, and resident rolled out the right side onto the floor The investigation form for NA-B dated 7/6/24 at 9:00 signed by DON indicated NA-B reported We were putting [resident room number] to bed like we always do. We made sure all the straps were hooked up. Resident [was] also checking to make sure he wasn't caught on anything and we started to lift him up and the strap on the right back snapped off and resident rolled out the right side onto his back .He was 2-3 feet up and it happened so fast there was nothing we could do. Both NA-H and NA-B's forms included Re-Education: discussed and educated CNA on the importance of checking and double checking the straps are properly hooked to hoyer. NOC [night] nurse on duty at the time of the fall educated staff on importance of checking straps during transfer. Nurse also observed res [resident] transfer in the a.m. with staff and hoyer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/25/24 at 2:27 p.m., RN-H stated she was called to R1's room around 11:00 p.m. on 7/5/24, because R1 had fallen from a mechanical lift. RN-H entered the room, R1 was on the floor beside the bed on his back. R1 was alert and oriented, she did not observe any obvious injuries, however, R1 complained of pain in his upper back and neck area but refused to go the ED. RN-H inspected both the lift and the sling. She did not see anything wrong with either but used a different sling to get R1 off the floor. RN-H stated she thought a large size sling was used for both transfers however could not say for sure. RN-H indicated the facility did not have an assessment or system for determining sling sizes however she would make sure the sling covered the shoulders to upper thighs. RN-H indicated the lift was not removed from the floor because she had found it was in working order. RN-H had not asked maintenance to inspect the lift, nor was the transfer sling inspected. RN-H further indicated that R1 was continuing to have on going pain and had gone to the emergency roiagnom on [DATE] and was found to not have any injuries. Review of the facility's maintenance logs for the Hoyer mechanical lifts for the months of June and July indicated all lifts were checked on 6/5/24, one lift was checked on 7/8/24, three days after R1's fall. The records indicated the remaining lifts were inspected on 7/25/24. The facility was using EZ-Way brand lifts rather than Hoyer brand lifts. R3's quarterly MDS dated [DATE], indicated R3 did not have cognitive impairment. R3 had no impairment of upper or lower extremities. R3 was dependent with all transfers and did not walk. R3's Nursing Assessment for Total Mechanical lift dated 6/21/22, indicated R3 required a Hoyer lift with two staff assistance. The assessment did not address size and type of sling. R3's ADL care plan 6/21/24 directed staff to transfer R3 with Hoyer lift with two staff. The care plan did not include the sling size and type that R3 required. R3's Nursing Assessment for Total Mechanical dated 7/25/24, indicated R3 required a Hoyer lift with two staff assistance. The summary included: Hoyer lift is appropriate and effective for transfers and two assist due to resident's decline in mobility. This assessment also did not address sling size and type. During an observation on 7/25/24 at 12:56 p.m., R3 sat in her recliner with a green sling underneath her. This sling size was extra-large per manufactures sizing guide on mechanical lift outside of room. During an observation on 7/25/24 at 1:11 p.m., nurse manager (NM)-A entered R3's room and verified that the sling R3 was sitting on was extra large in size. NM-A was not aware of how to measure for the appropriate sling size and type and indicated there was no process in place for completing sling assessments. During an interview on 7/25/24 at 3:20 p.m., EZ-Way lift representative (LR)- A stated the sling R3 was sitting on, was not the correct sling size. LR-A stated R3 should be a large sling size and not extra large. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R2's quarterly MDS dated [DATE], R2 had severe cognitive impairment. R2's diagnoses included hip fracture, Alzheimer's disease, and dementia. R2 was dependent for ADLs except required moderate assistance with eating. R2 had impairment on one side of her lower extremities and used a manual wheelchair. R2's Nursing Assessment for Total Mechanical lift dated 6/20/24, indicated R2 required a Hoyer lift with two staff assistance. The assessment did not address size and type of sling. R2's ADL care plan 6/20/24, for transfers directed staff to use a Hoyer lift with two staff. The care plan did not identify sling size and type that R2 required. R2's Nursing Assessment for Total Mechanical lift dated 7/25/24, indicated R2 required a Hoyer lift with two staff assistance. The assessment continued to lack mention of size and type of sling. During an interview on 7/25/24 at 10:25 a.m., NA-A stated an unawareness of how to properly determine sling size and would use the sling that was in the resident's rooms. NA-A thought nursing or therapy decided the sling size. During an interview on 7/25/24 at 10:51 a.m., NA-M indicated the sling size was dependent on the size and weight of the person. NA-M would check the sling size chart on the lift against the resident's weight. She would use whatever sling was in the room unless she questioned the fit. During an interview on 7/25/24 at 5:50 p.m., Administrator and DON both indicated if there was not anything wrong with the lift and the sling the cause of the fall would be operator error. DON and Administrator expected staff to follow the manufacturers recommendations for safety. Stated there had not previously been a process in place to determine proper sling size and staff were expected to follow the manufacturer's instructions. During an interview on 7/25/24 at 3:20 p.m., EZ-Way lift representative (LR)-A explained staff needed to check the tension of the sling loops/straps by touching each one to make sure they were secured onto the lift. This check is completed while the resident is being lifted and still on/over the surface that they are being raised off of. LR-A stated the correct sling sizes were important to prevent falls and injuries to both residents and staff. Additionally, with the correct sling size, the staff can obtain better resident placement in chair and bed without pushing or pulling on resident. EZ-Way Smart Lift Operator Manual included the following: WARNING: For safe operation of the EZ Way Lifts, the lift must be used by trained personnel in accordance with operators manual, video, and training checklist to avoid injury to patient. -do not modify the sling design in any way, make the accessories used with each lift are appropriate for both the patient and the transferring situation, -the sling size is calculated using the resident weight, height, and girth, a proper fir will involve judgement of the caregiver, - proper sling placement include top of sling at the shoulder level and the base of the sling two inches below the tail bone, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-while lifting the patient upward, continue until there is tension on the sling legs, making sure all the loops on the sling are securely hooked on the hanger bars before moving resident from over the surface transferring from, -all EZ Way equipment must be maintained regularly by competent staff according to the maintenance checklist provided.